Public Policy and Administration Research
ISSN 2224-5731(Paper) ISSN 2225-0972(Online)
Vol.2, No.2, 2012

Embarking on health policy changes for bringing oral health towards school aged children

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Abstract

The modest goal of World Health Organization (WHO), of reducing DMFT (Decayed, Missing, Filled teeth) to below 3 for 12- year old and caries prevalence below 50 -60% for 5-6 year olds has not been achieved in developing countries. In most of the developing countries including India, these goals are unlikely to be achieved in the next decade or more without a major change in the health policies and delivery system.

Keywords: developing country, health policy, school children, oral health

Short Report

The modest World Health Organization (WHO) goal of reducing DMFT (Decayed, Missing, Filled teeth) to below 3 for 12- years old and caries prevalence below 50 -60% for 5-6 year olds has not been achieved in developing countries. In most of the developed countries including India, these goals are unlikely to be achieved in the next decade or more without a major change in the health policies and delivery system.

Barriers exist that prevent many school aged children, not all of whom are poor, from accessing dental care that cannot be overcome by traditional private practice. These barriers include the high cost of fee for service; geographical maldistribution of dentists; disinclination of many dentists to treat poor and minority children. No less significant are the social barriers that include ethnic/cultural attitudes and values, deficient education and inadequate transportation.

If oral health care of all children have to be taken care, rich and poor alike, then better ways to bring oral health care to children have to be considered. We must acknowledge the obvious fact that with respect to health care, children are essentially non ambulatory. They must have someone with the desire, time money and means to take them to health care provider. If there is no one to bring these children to dental care, then dental care must be provided for them in schools.

School health programs have and are being conducted successfully in developed countries. In developing countries similar programs need to be conducted. The problem being faced is of funding. Who is going to fund these programs? Will it be the government, the school authorities or the public?

Let us first try to understand the problem prior to reaching any conclusions. Developing countries have been consistent in allotting only a fraction of their budget on health. Specifically for oral health, in India there is no existing state or central funding. Ultimate responsibility for the performance of a countries health system lies with the government of that country. We can therefore say that either if school health programs have to develop; then it has to be through the government, be it state or central.

The source of funding being clear now it will be up to the policy makers to decide how to go about it. School dental clinics are one of the available options. Due to the number of schools, school children and dearth of funds then as an alternative dentist may be appointed to examine the school children. Special emphasis need to be given to oral health education and on prevention of oral diseases. An efficient referral and follow up system need to be developed. Dentist, dental hygienist, dental nurse or even a trained teacher may be used to conduct such educational programs based on the availability of resources.

The government has a duty towards its people, this need to be kept in mind when framing the health policies. How we allocate available funds and services will determine if we succeed in meeting the set goals. Separate funds need to be earmarked for oral health in developing countries. The oral health problems of children cannot be neglected and neither can they be blamed for their poor oral health conditions. If we want school aged children to benefit from adequate oral health care, then it needs to be provided in school health programs, where it can be easily accessed.